



April 2017

MEDICARE ADVANTAGE

CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight

GAO Highlights

Highlights of [GAO-17-393](#), a report to congressional requesters

Why GAO Did This Study

In 2016, over 30 percent of Medicare beneficiaries were enrolled in the MA program. Each year beneficiaries have an opportunity to join or leave their MA plan.

GAO was asked to review MA disenrollment by health status and CMS oversight. This report examines, among other issues, (1) the extent of any health-biased disenrollment, (2) beneficiaries' reasons for leaving contracts with and without health biased disenrollment, and (3) how, if at all, CMS identifies contracts with health-biased disenrollment, for routine oversight purposes.

GAO analyzed 2014 disenrollment rates for the 252 MA contracts that had a sufficient number of disenrollees and met other criteria. For the 126 contracts with disenrollment rates above the median rate, GAO used beneficiaries' projected health care costs to identify those in poor health and better health. GAO examined data from CMS's Disenrollment Reasons Survey to learn why beneficiaries reported leaving the 126 contracts with relatively high disenrollment rates. GAO also interviewed CMS officials and compared their oversight to federal standards for internal control.

What GAO Recommends

To strengthen its oversight of MA contracts, CMS should examine data on disenrollment by health status and the reasons beneficiaries disenroll. HHS concurred with GAO's recommendation.

View [GAO-17-393](#). For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

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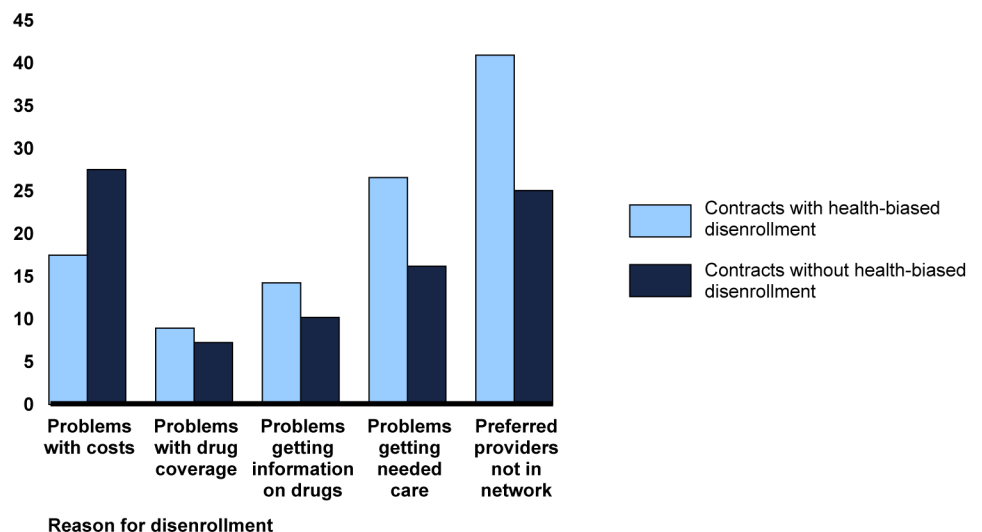
CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight

What GAO Found

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) contracts with private entities to offer coverage for Medicare beneficiaries. GAO examined 126 contracts with higher disenrollment rates—above the median rate of 10.6 percent in 2014—and found 35 contracts with health-biased disenrollment. In these contracts, beneficiaries in poor health were substantially more likely (on average, 47 percent more likely) to disenroll relative to beneficiaries in better health. Such disparities in contract disenrollment by health status may indicate that the needs of beneficiaries, particularly those in poor health, may not be adequately met.

GAO found that beneficiaries who left the 35 contracts with health-biased disenrollment tended to report leaving for reasons related to preferred providers and access to care. In contrast, beneficiaries who left the 91 contracts without health-biased disenrollment tended to report that they left their contracts for reasons related to the cost of care.

Disenrollment Reasons Survey Responses for the 126 Medicare Advantage Contracts with Relatively High Disenrollment, 2014
Percent of contracts



Source: GAO review of Centers for Medicare & Medicaid Services's Disenrollment Reasons Survey reports. | GAO-17-393

CMS does not use available data to examine data on disenrollment by health status as part of its ongoing oversight; thus, CMS may fail to identify problems in MA contract performance, which poses a risk as contracts are prohibited from limiting coverage based on health status. CMS's oversight is inconsistent with internal control standards.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
HMO	health maintenance organization
MA	Medicare Advantage
MAO	Medicare Advantage organization
PFFS	private fee-for-service
PPO	preferred provider organization
SNP	special needs plan

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April 28, 2017

The Honorable Rosa L. DeLauro
Ranking Member
Subcommittee on Labor, Health and Human Services, Education, and
Related Agencies
Committee on Appropriations
House of Representatives

The Honorable Sherrod Brown
United States Senate

The Medicare Advantage (MA) program, under which private entities—known as MA organizations (MAO)—contract with the Centers for Medicare & Medicaid Services (CMS) to provide health care coverage to Medicare beneficiaries, has grown in recent years.¹ MA enrollment has increased from 11.1 million in 2010 to 17.6 million in 2016, and the program now accounts for nearly a third of all Medicare beneficiaries—more than in any previous year. Under MAOs’ contracts, beneficiaries may typically choose from a wide array of plans that vary in their coverage, costs, and provider networks.² Medicare requires MAOs to accept all beneficiaries who want to enroll in a plan, and the program has certain protections in place to ensure that the needs of beneficiaries in poor health are adequately met.³ For example, MAOs are prohibited from limiting or conditioning their coverage or provision of benefits based on health status, and CMS may not approve bids for MA contracts with plans that have benefit packages that discourage the enrollment of certain beneficiaries, such as those with chronic conditions.⁴ In addition, CMS

¹CMS is the agency within the Department of Health and Human Services that administers the Medicare program.

²An MAO, such as Aetna, may have one or several contracts with CMS with each contract offering different plan benefit packages, such a standard plan or an enhanced plan, which provide a different mix of costs and benefits.

³For the purposes of this report, we refer to MA enrollees as beneficiaries.

⁴42 U.S.C. § 1395w-22(b)(1)(A); 42 C.F.R. §§ 422.100(f) (2016). CMS enforces such antidiscrimination requirements by, for example, monitoring cost sharing for services such as cardiac and pulmonary rehabilitation services.

requires that MAOs develop provider networks that ensure adequate access to covered services for all beneficiaries.⁵

Because MAOs can change their plan offerings from one year to the next, CMS encourages MA beneficiaries to review their enrollment decisions annually and consider which plan best meets their needs. Beneficiaries may choose to remain in their current plan, enroll in another plan offered under the same MAO contract, enroll in a plan offered under a different contract, or enroll in traditional Medicare.⁶ Each MAO contract is specific to a plan type—such as a health maintenance organization (HMO) or a preferred provider organization (PPO)—but each contract may include a variety of plan benefit packages (referred to as a plan) for beneficiaries to select, each with its own unique mix of cost sharing requirements and covered benefits.⁷

Consequently, beneficiaries who choose to enroll in a different plan under the same MA contract, have elected to stay in the same type of plan (e.g., HMO or PPO) offered by the same MAO. In contrast, beneficiaries who choose to enroll in a plan offered under a different contract have elected to enroll in a different type of plan or one offered by a different MAO. In 2014, nearly 12 percent of beneficiaries chose to leave their MA contract, due to a number of potential factors. Contract-level disenrollment may indicate a well-functioning competitive local MA market with competing MAOs seeking to attract beneficiaries to their plans by offering additional benefits or lower premiums and cost sharing. Alternatively, disenrollment may indicate that beneficiaries encountered access or quality issues. These beneficiaries may disenroll, for example, if their preferred provider is no longer in the plan's network or if they believe that their health care needs have not been well met.

⁵Part C-Medicare Advantage Application, §§ 2.8; 3.11.A.; See also 42 C.F.R. § 422.112(a)(1)(i) (2016). For additional information on CMS oversight of MA network adequacy, see GAO, *Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy*, [GAO-15-710](#) (Washington, D.C.: Aug. 31, 2015).

⁶In traditional fee-for-service Medicare, Medicare pays providers who submit claims for reimbursement after services have been rendered. Beneficiaries pay a premium, deductible, and any applicable cost sharing, and may elect to receive covered benefits from any Medicare participating provider.

⁷HMOs generally restrict beneficiary access to providers in their network. PPOs also have networks, but allow beneficiaries access to non-network providers by paying higher cost sharing amounts when receiving care from these providers.

While disenrollment among some of a contract's beneficiaries is expected, disparities in disenrollment rates between beneficiaries with different health care needs can be a sign of potential problems with a contract. If MAOs are meeting the needs of all their beneficiaries, we would expect that the rates at which beneficiaries disenroll would not vary by their health status. However, when beneficiaries in poor health are more likely to disenroll than those in better health—which we refer to as health-biased disenrollment—it may indicate that those beneficiaries could be facing problems with access to care or the quality of services provided.⁸ From an oversight perspective, contracts with health-biased disenrollment may not warrant extra CMS scrutiny if relatively few beneficiaries choose to leave the contract. However, contracts with both high overall rates of disenrollment and health-biased disenrollment may indicate potentially problematic contracts.

Given questions about the care beneficiaries in poor health receive in MA, you asked us to review MA disenrollment by health status and any related CMS oversight. In this report, we examined

1. the extent to which disenrollment rates vary across MA contracts;
2. the extent of any health-biased disenrollment among MA contracts;
3. how the characteristics of those contracts with health-biased disenrollment, if any, compare to those of other contracts;
4. the reasons beneficiaries give for leaving those contracts with health-biased disenrollment, if any, compared with other contracts; and
5. how, if at all, CMS identifies contracts with health-biased disenrollment as part of its routine oversight of MA contracts.

⁸Some studies have found that beneficiaries in poor health may be more likely than beneficiaries in better health to leave their MA contracts and join traditional Medicare. See Momotazur Rahman, et al., "High-Cost Patients Had Substantial Rates of Leaving Medicare Advantage and Joining Traditional Medicare," *Health Affairs*, vol. 34, no. 10 (2015); Gretchen Jacobson, et al., "At Least Half of New Medicare Advantage Enrollees Had Switched From Traditional Medicare During 2006-11," *Health Affairs*, vol. 34, no. 1 (2015); and Gerald F. Riley, "Impact of Continued Biased Disenrollment from the Medicare Advantage Program to Fee-for-Service," *Medicare & Medicaid Research Review*, vol. 2, no. 4 (2012).

Methodology

To examine variation in MA disenrollment by contract, we examined CMS enrollment and disenrollment data for 2014—the most recent year of data available at the time of our analysis—for 252 contracts.⁹ We selected these 252 contracts as they had at least 100 disenrollees in poor health and 100 disenrollees in better health as well as had at least 50 percent of the individual measures in the 2016 MA Five-Star Rating System—which largely reflected performance in 2014.¹⁰ These contracts accounted for 80 percent of the 17.5 million beneficiaries enrolled in an MA contract that year.¹¹ We calculated the disenrollment rate for each of these contracts and designated the 126 contracts above the median rate of 10.6 percent as having relatively high disenrollment rates and the 126 contracts below the median rate as having relatively low disenrollment rates. (See appendix I for more details on the selection of the contracts included in our study.)

To determine the extent of health-biased disenrollment, if any, among MA contracts, we focused our analysis on the 126 MA contracts with higher disenrollment rates.¹² We used CMS risk score data to identify beneficiaries in poor health and beneficiaries in better health. Specifically, beneficiaries whose projected spending was at least twice as much as that for the average Medicare beneficiary were characterized as being in poor health, while the remaining beneficiaries with projected spending

⁹CMS data on MA enrollment and disenrollment are at the contract level and exclude those enrolled in employer-sponsored contracts. These disenrollment data do not account for beneficiaries who enrolled in another plan offered under the same contract. The data also exclude beneficiaries who involuntarily disenrolled for reasons that included moving outside of their contract service area, experienced a contract closure, or death. For beneficiaries who switched contracts multiple times during the year, we counted each change as a separate disenrollment.

¹⁰There were 480 contracts, with 3.6 million beneficiaries that we excluded from our analysis. These contracts had less than 100 disenrollees in poor health or 100 disenrollees in better health, or contracts for which CMS reported fewer than 50 percent of the individual measures in the 2016 MA Five-Star Rating System—which largely reflected performance in 2014.

¹¹Beneficiaries may have been enrolled in more than one contract in 2014 and our beneficiary enrollment calculation accounts for the total number of unique enrollments in each MA contract. According to CMS, there were 15.9 million beneficiaries enrolled in December 2014.

¹²We excluded contracts with below median disenrollment as they may not warrant the same level of oversight scrutiny as those with higher rates.

less than that amount were considered to be in better health.¹³ Using this information for each of the 126 contracts, we then calculated disenrollment odds ratios to determine the likelihood that beneficiaries in poor health disenrolled from the contract compared to beneficiaries in better health. For example, an odds ratio of 1.50 signifies that those in poor health were 50 percent more likely to disenroll than those in better health.¹⁴ We deemed contracts with an odds ratio over 1.25—where the likelihood that poor health beneficiaries disenrolled was more than 25 percent greater than that of beneficiaries in better health—as having health-biased disenrollment.¹⁵ We deemed those contracts with an odds ratio of 1.25 or less as lacking health-biased disenrollment.

To examine the characteristics of contracts with and without health-biased disenrollment, we focused our analysis on the 126 MA contracts with higher disenrollment rates in 2014. We analyzed CMS data for 2014 on a number of contract variables, including enrollment size and the number of years of experience in the MA program. In addition, we compared the quality ratings of contracts in each group based on data from the MA Five-Star Rating System. These data comprise an overall star rating for each MA contract as well as each contract's performance scores on up to 47 individual measures—such as controlling blood pressure—grouped within 9 domains—such as managing chronic

¹³We used Medicare risk score information on each beneficiary, which is used to set payment rates to MA plans. CMS develops risk scores based on demographic and diagnosis information that are used project how much it will cost to provide care for each beneficiary. The average score is 1; higher scores correspond to higher predicted health care costs. For example, a score of 2.0 would indicate a beneficiary has projected spending twice the national average. We classified beneficiaries with risk scores of 2.0 or higher as having poor health and those with risk scores of less than 2.0 as being in better health.

¹⁴For example, a hypothetical contract had 500 beneficiaries in poor health, of which 100 disenrolled and 400 remained in the contract. In this case, for every one beneficiary who disenrolled, four remained. Of the 600 beneficiaries in good health in the same contract, 100 disenrolled. In this case, for every 1 beneficiary who disenrolled, five remained. The relationship between these two calculations can be expressed as an odds ratio, which in this case would be $(1/4) / (1/5) = 1.25$.

¹⁵An odds ratio over 1.0 indicates some degree of health-biased disenrollment. To ensure that we captured contracts with a sizeable amount of health-biased disenrollment, we defined those contracts with odds ratio over 1.25 as having health-biased disenrollment. Disenrollment odds for each health group were calculated as the number of beneficiaries who disenrolled divided by the number who stayed in the contract.

conditions.¹⁶ We determined the median score for individual performance measures for all contracts in the rating system. For both the contracts with and without health-biased disenrollment, we then determined the percentage of measures within each domain that had better than median scores; we characterized these contracts as having relatively high quality.¹⁷

To examine the reasons beneficiaries chose to disenroll from contracts with and without health-biased disenrollment, we analyzed CMS's Disenrollment Reasons Survey reports. The reports are compiled for MA contracts based on surveys sent to a representative sample of disenrollees to learn about why they elected to leave their plan. CMS combined survey responses into one of five composite reasons for disenrollment: problems with costs, problems with drug coverage, problems getting information on drugs, problems getting needed care, and preferred providers not in network.¹⁸ For each of the 126 MA contracts with higher disenrollment rates, we compared the average percentage of respondents who identified each composite reason, for contracts with and without health-biased disenrollment.¹⁹

To examine how, if at all, CMS identifies contracts with health-biased disenrollment as part of its routine oversight of MA contracts, we reviewed the agency guidance and data provided to its regional offices and interviewed CMS officials. In addition, we compared the set of contracts

¹⁶For our analysis, we used the 2016 Part C and Part D Star ratings, which we refer to as the MA Five-Star Rating System. These ratings largely reflect beneficiaries experience in 2014. However, about a quarter of the measures reflect a time period that overlaps 2014 (e.g., 2013-2014) and about 10 percent reflect the first half of 2015. The ratings apply to all plans within a given contract. CMS applies different weights to each measure to reflect its importance and assigns each contract an overall star rating. For example, CMS assigns greater weight to outcome measures, which focus on improvement to a beneficiary's health, with less weight assigned to process measures, which evaluate the method by which health care is provided.

¹⁷For some measures—such as the contract's complaint rate and disenrollment rate—lower scores represented better performance. In these instances, we defined relatively high quality as a score that was at or below the median score for that measure.

¹⁸For example, the composite reason "problems with drug benefits and coverage" included problems with desired drugs not being included on the plan's formulary or because the plan refused to pay for a prescribed drug.

¹⁹Response rates varied by contract, and beneficiaries were able to select more than one reason for disenrolling from their contract. We only analyzed those contracts with responses that CMS determined were reliable.

identified by CMS as having potential problems in 2014 with the contracts we identified as having health-biased disenrollment. We examined CMS's oversight in the context of relevant standards for internal control in the federal government.²⁰

We assessed the reliability of the data from CMS that we analyzed by reviewing relevant documentation and examining the data for obvious errors. We determined that the data were sufficiently reliable for the purposes of our reporting objectives.

We conducted this performance audit from November 2015 to April 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The MA program—also known as Medicare Part C—is the private plan alternative to the traditional Medicare program.²¹ Instead of paying providers' claims directly, CMS contracts with MAOs to assume the risk of providing health benefits to beneficiaries in exchange for fixed monthly payments. The payment amounts vary, in part, depending on the relative health status of the MAO's beneficiaries as compared to the health status of an average Medicare beneficiary. CMS paid almost \$170 billion to MAOs in 2015.

MAOs must provide coverage for all traditional Medicare services and include a yearly limit on out-of-pocket costs.²² Most plans also include prescription drug coverage offered under Medicare Part D. Plans may offer more generous benefits, such as less cost sharing and additional covered services, such as vision or dental care. To control utilization,

²⁰GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: September 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

²¹MA beneficiaries must pay the Medicare monthly premium. Some plans may charge an additional monthly premium, while others may offer a reduction on the Medicare premium.

²²MAOs are not required to cover hospice care as hospice services provided to MA beneficiaries are covered under traditional Medicare.

plans may impose referral requirements and implement care coordination programs. MA beneficiaries' access to providers is generally limited to a network of physicians, hospitals, and others that contract with their MAO. If a given physician or hospital is not in the MA plan's network, the beneficiary's out-of-pocket cost to use that physician or hospital may be considerably higher than the cost associated with using providers in the plan's network.

Beneficiaries may choose from the plans available in their county, which may be provided by multiple contacts. The contracts represent various types of plans, including HMOs, PPOs, and private fee-for-service (PFFS) plans. HMOs, which according to CMS, accounted for nearly three-fourths of MA enrollment in 2016, generally restrict beneficiary access to providers in their network. PPOs, which according to CMS, accounted for nearly one-fourth of 2016 MA enrollment, also have networks, but allow beneficiaries access to non-network providers by paying higher cost sharing amounts. In contrast, PFFS plans, which accounted for 1 percent of MA enrollment in 2016, generally offer a wider choice of providers.²³ A subset of HMOs and PPOs are special needs plans (SNP) which provide care for beneficiaries in one of three classes of special needs. Medicare beneficiaries can enroll in a SNP if they are dually eligible for Medicare and Medicaid, require an institutional level of care, or have a severe or chronic condition.²⁴

While beneficiaries are generally locked into their MA plan for a year (January through December), they may voluntarily leave their plan at certain times in the year or if they meet certain criteria. During the annual open enrollment period, from October 15 to December 7, MA beneficiaries may change their MA plan selection or join traditional Medicare. This is followed by the MA disenrollment period, from January 1 to February 14, when MA beneficiaries may join traditional Medicare and are allowed to select a drug plan to go with their new coverage. In addition, CMS has special enrollment periods where MA beneficiaries may change their enrollment under certain circumstances. For example, Medicare beneficiaries can switch to a contract with an overall Five-Star rating of 5 from December 8 to the following November 30. In addition,

²³PFFS plans are required to have networks in service areas where two or more HMOs or PPOs operate. In other areas, PFFS beneficiaries are free to use any Medicare provider.

²⁴Dual-eligible beneficiaries are those who are eligible for both Medicare and Medicaid, a joint federal-state program that finances health insurance coverage for certain categories of low-income or disabled people.

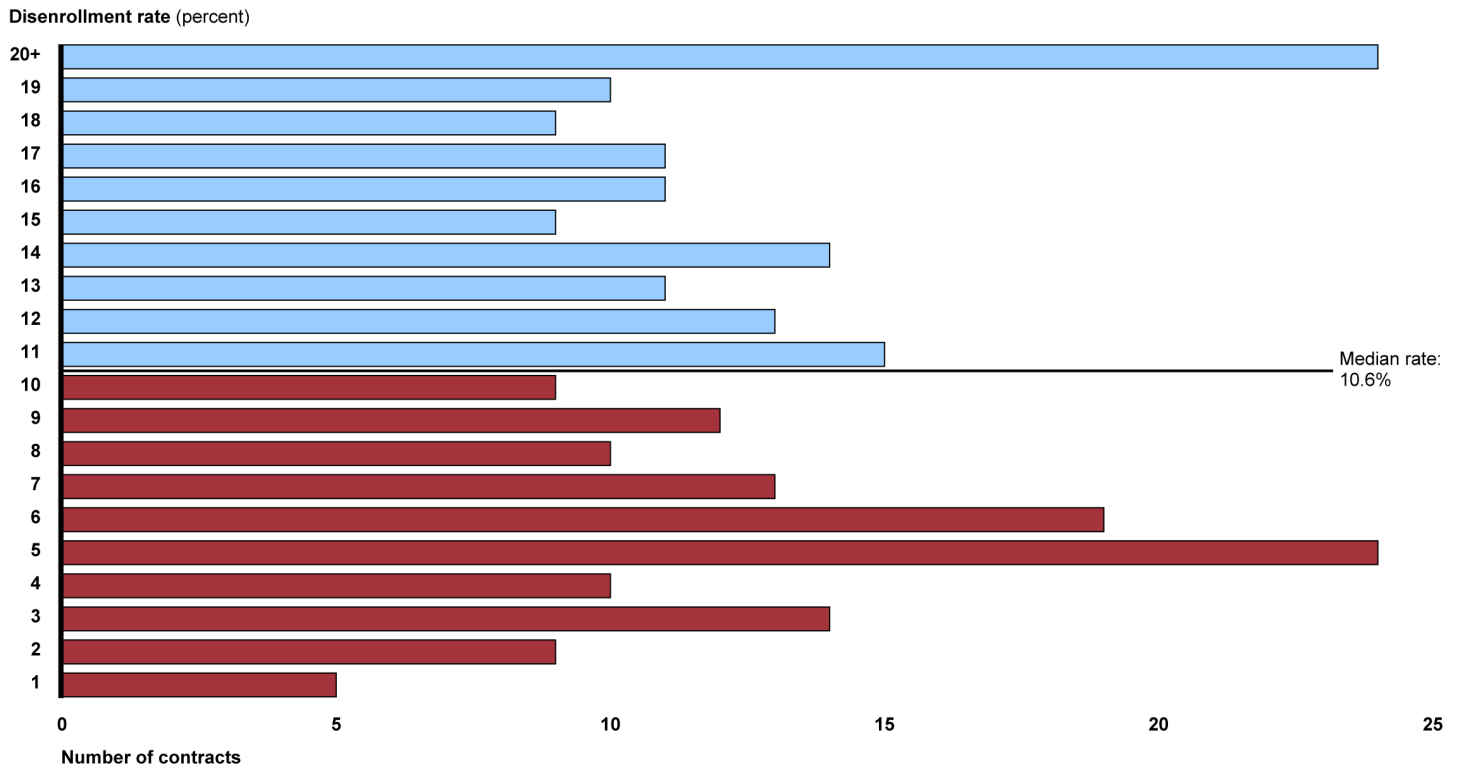
dual-eligible beneficiaries may change their MA enrollment on the first day of any month.

2014 MA Contract Disenrollment Rates Ranged from 1 to 39 Percent

In 2014, disenrollment rates varied widely among the 252 contracts in our analysis, ranging from 1 to 39 percent.²⁵ (See fig. 1.) The 126 contracts with high disenrollment rates—those with rates above the median rate of 10.6 percent—accounted for 38 percent of the MA population in our study. Moreover, these contracts accounted for over two-thirds of total disenrollment in our population. Nineteen percent of this group of contracts—24 contracts—had disenrollment rates of 20 percent or greater. In contrast, contracts with relatively low disenrollment rates accounted for 62 percent of the MA population in our study. Nearly half of these contracts had disenrollment rates at or below 5 percent.

²⁵Enrollment in these 252 contracts ranged from about 1,600 to over 1 million beneficiaries.

Figure 1: Distribution of Disenrollment Rates across 252 Medicare Advantage Contracts, 2014



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-393

Note: Excluded from our analysis were 480 contracts with fewer than 100 disenrollees in poor health and 100 disenrollees in better health, or contracts for which CMS reported fewer than 50 percent of the individual measures in the 2016 MA Five-Star Rating System—which largely reflected performance in 2014. We used CMS data to identify beneficiaries in relatively poor health—those with projected spending at least twice as much as that for the average Medicare beneficiary.

Health-biased Disenrollment Found in One-Quarter of MA Contracts with Higher Disenrollment Rates

Where did beneficiaries go when they chose to leave their MA contract with high disenrollment?

The majority—84 percent—switched to another MA contract in 2014. The remaining 16 percent enrolled in traditional Medicare. Such a high rate of switching among MA contracts may reflect general satisfaction with the MA program. However, it may also reflect certain barriers disenrollees may face in opting for traditional Medicare. For instance, beneficiaries may have difficulty obtaining a supplemental Medigap insurance policy from a private insurer when enrolling in traditional Medicare outside of the initial enrollment period.⁹ Even MA beneficiaries in relatively poor health—those with projected spending at least twice as much as that for the average Medicare beneficiary—tended to switch MA contracts instead of opting for traditional Medicare: 79 percent of beneficiaries in poor health who disenrolled from their MA plan in 2014 chose to remain in MA.

Source: GAO. | GAO-17-393

⁹Beneficiaries enrolling in traditional Medicare have the option of purchasing private supplemental insurance to help cover cost sharing amounts. Beneficiaries are able to purchase this coverage without medical underwriting at certain times. However, beneficiaries who enrolled in MA upon becoming Medicare eligible and enroll in traditional Medicare after 12 months may be subject to medical underwriting as part of enrolling in a Medigap plan.

Among the 126 contracts with higher disenrollment rates, we found that 35 contracts had health-biased disenrollment—meaning that beneficiaries in poor health were substantially more likely to leave their contracts than those in better health. These contracts accounted for 15 percent of beneficiaries in higher disenrollment contracts, or approximately 810,000 beneficiaries. For these 35 contracts, on average, beneficiaries in poor health were 47 percent more likely to disenroll relative to beneficiaries in better health. For individual contracts, this percentage ranged from 27 to 126 percent.

Among the remaining 91 contracts with higher disenrollment rates, we did not find evidence of health-biased disenrollment—meaning that in these contracts, beneficiaries in poor health had, on average, odds of disenrollment similar to beneficiaries in better health. Specifically, both disenrollees in poor health and disenrollees in better health had a 1 in 5 chance of disenrolling from their contract. In total, the 91 contracts accounted for 4.5 million beneficiaries, or 85 percent of the enrollment in the MA contracts with higher rates of disenrollment in our review.

Contracts with Health-biased Disenrollment Had Lower Enrollment, a Greater Proportion of HMOs, and Relatively Low Quality Ratings, among Other Differences

Contracts with Health-biased Disenrollment Had Low Enrollment and a Greater Proportion of HMOs, among Other Differences, Compared with Other Contracts

We found several notable differences when comparing the characteristics of the 35 contracts with health-biased disenrollment with the 91 contracts without health-biased disenrollment. Specifically, the 35 health-biased disenrollment contracts were more likely to have the following:

- Lower enrollment. Sixty-nine percent of health-biased disenrollment contracts had fewer than 15,000 enrollees.²⁶ This percentage was lower for contracts without health-biased disenrollment—25 percent. In addition, a smaller percentage of health-biased disenrollment contracts—11 percent—had enrollment that exceed 50,000 beneficiaries. In contrast, 29 percent of contracts without health-biased disenrollment had enrollments that large.
- Higher proportion of HMOs. Ninety-one percent of health-biased disenrollment contracts were HMOs—which feature closed provider networks—while only 9 percent were PPOs. In contrast, for contracts without health-biased disenrollment, 70 percent were HMOs and 25 percent were PPOs.
- Larger share of SNP enrollees. Contracts with health-biased disenrollment tended to have a higher proportion of beneficiaries in SNPs—which provide targeted care for special needs individuals, such as those with chronic conditions. On average, 37 percent of these contracts had a majority of their beneficiaries in SNPs

²⁶Contracts with health-biased disenrollment had an average of 23,000 beneficiaries, while contracts without health bias averaged 50,000 beneficiaries.

compared with 21 percent, on average, for the contracts without health-biased disenrollment.

- Less time in MA program. The contracts with health-biased disenrollment had, on average, fewer years in the MA program compared to the contracts without health-biased disenrollment—an average of 8 years compared to 12 years, respectively. (See table 1 for a comparison of the characteristics of contracts with and without health-biased disenrollment.)

Table 1: Characteristics of 126 Medicare Advantage Contracts with Relatively High Disenrollment Rates, 2014

Characteristics	Percentage of contracts	
	Contracts with health-biased disenrollment (n=35)	Contracts without health-biased disenrollment (n=91)
Size of contract		
% Small (<=15,000 beneficiaries)	69	25
% Medium (15,001-50,000 beneficiaries)	20	46
% Large (>=50,001 beneficiaries)	11	29
Type of contract		
Health maintenance organization	91	70
Preferred provider organization	9	25
Private fee-for-service	0	4
Enrollment in special needs plans (SNP)		
% Majority SNP enrollment	37	21
Medicare Advantage experience		
Average number of years in program	8	12

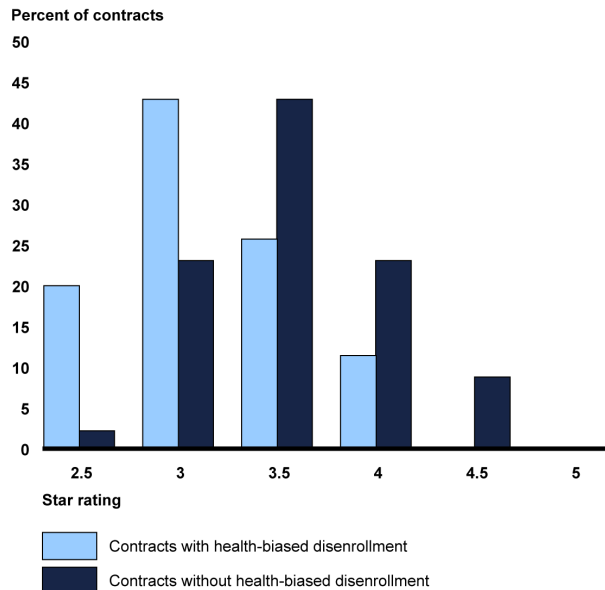
Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-393

Note: This analysis includes the 126 contracts with 2014 disenrollment rates above the median rate of 10.6 percent among contracts in our study. We calculated odds ratios for each contract to determine the likelihood that beneficiaries in poor health had of disenrolling relative to those in better health. We used CMS data to identify beneficiaries in relatively poor health—those with projected spending at least twice as much as that for the average Medicare beneficiary. Contracts with odds ratios over 1.25 were designated as having health-biased disenrollment, and contracts with odds ratios of 1.25 or less were considered to be without health-biased disenrollment.

Contracts with Health-biased Disenrollment Scored Lower on Overall Quality and Individual Performance Measures Than Other Contracts

Our analysis of data from CMS’s MA Five-Star Rating System showed that the contracts with health-biased disenrollment generally had lower overall quality ratings than contracts without health-biased disenrollment.²⁷ (See fig. 2.) Among the 126 contracts with higher disenrollment rates, nearly two-thirds of the health-biased contracts had three or fewer stars compared to about one-fourth of the contracts without health-biased disenrollment. Furthermore, only 11 percent of contracts with health-biased disenrollment had four or more stars compared to 32 percent of the contracts without health-biased disenrollment.

Figure 2: 2016 Star Ratings among 126 MA Contracts with Relatively High Disenrollment Rates



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-393

Notes: This analysis includes the 126 contracts with 2014 disenrollment rates above the median rate of 10.6 percent among contracts in our study. We calculated odds ratios for each contract to determine the likelihood that beneficiaries in poor health had of disenrolling relative to those in better health. We used CMS data to identify beneficiaries in relatively poor health—those with projected spending at least twice as much as that for the average Medicare beneficiary. Contracts with odds

²⁷ CMS developed the Five-Star Rating System—which includes measures on outcomes and patient experience—as a way to gauge whether beneficiaries were getting high-quality care from their MAOs. CMS publishes the star ratings each year to assist beneficiaries in selecting a plan within a given contract as well as to determine bonus payments to MAOs. Forty percent of contracts had four or more stars overall and received bonus payments from CMS in 2016.

ratios over 1.25 were designated as having health-biased disenrollment and contracts with odds ratios of 1.25 or less were considered to be without health-biased disenrollment.

CMS's 2016 MA Five-Star Rating System is used to evaluate contracts on up to 47 quality and performance measures. These ratings largely reflect beneficiaries' experience in 2014. However, about a quarter of the measures reflect a time period that overlaps 2014, e.g., 2013-2014 and about 10 percent reflect the first half of 2015.

In addition, the contracts with health-biased disenrollment scored lower than the contracts without health-biased disenrollment across each of the nine performance domains in the MA Five-Star Rating System.²⁸ We found a smaller share of the 35 contracts with health-biased disenrollment had better than median quality scores when compared to the 91 contracts without health-biased disenrollment. For example, only 36 percent of the contracts with health-biased disenrollment had better than median scores on managing chronic (long-term) conditions, which include measures on blood pressure and diabetes care. In contrast, 52 percent of the contracts without health-biased disenrollment performed above the median on this performance domain. (See table 2.)

Table 2: Percentage of 126 MA Contracts with Relatively High Disenrollment Rates That Have Better Than Median Performance on MA Five-Star Measures, 2014

Medicare domain	Percentage of contracts with better than median performance scores	
	Contracts with health-biased disenrollment (n=35)	Contracts without health-biased disenrollment (n=91)
Medicare Advantage (Part C)		
Staying healthy: screenings, tests and vaccines	39	50
Managing chronic (long-term) conditions	36	52
Member experience with health plan	18	42
Fewer member complaints; changes in health plan's performance	28	37
Health plan customer service	40	62
Average percentage	32	49
Prescription drug (Part D)		
Drug plan customer service	46	65
Fewer member complaints; changes in drug plan's performance	25	31

²⁸In addition to assigning contracts an overall rating under the MA Five-Star Rating System, CMS also evaluates contracts on a range of quality measures and consolidates the individual measures into broader domains. These domains include such areas as management of chronic (long-term) conditions, complaints, and health plan customer service.

Medicare domain	Percentage of contracts with better than median performance scores	
	Contracts with health-biased disenrollment (n=35)	Contracts without health-biased disenrollment (n=91)
Member experience with drug plan	36	51
Drug safety and accuracy of drug pricing	34	52
Average percentage	35	50
Overall percentage	34	49

Source: GAO review of Centers for Medicare & Medicaid Services data. | GAO-17-393

Notes: This analysis includes the 126 contracts with 2014 disenrollment rates above the median rate of 10.6 percent among contracts in our study. We calculated odds ratios for each contract to determine the likelihood that beneficiaries in poor health had of disenrolling relative to those in better health. We used CMS data to identify beneficiaries in relatively poor health—those with projected spending at least twice as much as that for the average Medicare beneficiary. Contracts with odds ratios over 1.25 were designated as having health-biased disenrollment and contracts with odds ratios of 1.25 or less were considered to be without health-biased disenrollment.

Using data from the 2016 MA Five-Star Rating System, we determined the median performance score across all MA contracts for each measure and determined the proportion contracts that performed better than the median score. These ratings largely reflect beneficiaries experience in 2014. However, about a quarter of the measures reflect a time period that overlaps 2014, e.g., 2013-2014 and about 10 percent reflect the first half of 2015.

Beneficiaries Reported Different Reasons for Disenrolling from Contracts with and without Health-Biased Disenrollment

Our review of CMS’s Disenrollment Reasons Survey reports showed that beneficiaries who disenrolled from the 35 contracts with health-biased disenrollment tended to report that they did so for reasons related to provider coverage. In contrast, beneficiaries who disenrolled from the 91 contracts without health-biased disenrollment tended to report that they left their contracts for reasons related to the cost of care. (See fig. 3.) Specifically, we found the following:

- Beneficiaries who left the 35 contracts with health-biased disenrollment commonly reported disenrolling because their preferred doctor or hospital was not covered by their MA contract.²⁹ This reason was cited by 41 percent of surveyed disenrollees, on average, across the contracts with health-biased disenrollment. In contrast, the same reason was cited by 25 percent of surveyed disenrollees, on average, across the contracts without health-biased disenrollment.
- Beneficiaries in contracts with health-biased disenrollment were more likely to report problems obtaining needed care, obtaining information

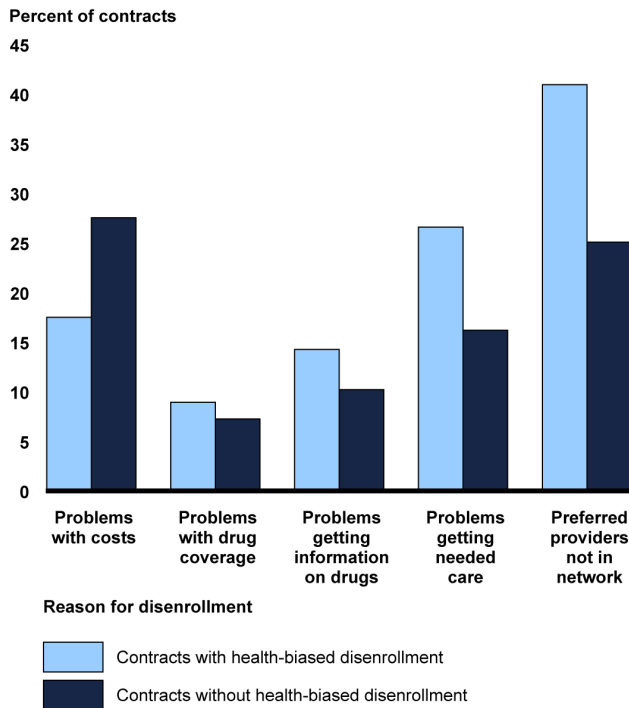
²⁹Beneficiaries may lack accurate information on network providers. A 2016 CMS review of 54 Medicare plans’ directories found that nearly half of the online physician listings were incorrect. For additional information on CMS oversight of MA network adequacy, see [GAO-15-710](#).

on drugs, and with drug coverage. For example, on average, 27 percent of surveyed disenrollees from contracts with health-biased disenrollment reported difficulty getting needed care. In contrast, 16 percent of surveyed disenrollees from contracts without health-biased disenrollment cited these reasons.

- Beneficiaries who left the 91 contracts without health-biased disenrollment were more likely to report financial reasons for disenrolling.³⁰ On average, 28 percent of disenrollees from these contracts identified problems with costs, compared with 18 percent of disenrollees from contracts with health-biased disenrollment. For example, when asked whether the presence of another plan that costs less was a reason for disenrolling, 45 percent of disenrollees from the contracts without health-biased disenrollment cited this reason, compared with 27 percent of beneficiaries who left contracts with health-biased disenrollment.

³⁰Financial reasons included “monthly premium went up,” “prescription copayment went up,” “found a plan that costs less,” and “could no longer afford plan.”

Figure 3: Disenrollment Reasons Survey Responses for the 126 Medicare Advantage Contracts with Relatively High Disenrollment Rates, 2014



Source: GAO review of Centers for Medicare & Medicaid Services's Disenrollment Reasons Survey reports. | GAO-17-393

Notes: This analysis includes the 126 contracts with 2014 disenrollment rates above the median rate of 10.6 percent among contracts in our study. We calculated odds ratios for each contract to determine the likelihood that beneficiaries in poor health had of disenrolling relative to those in better health. We used CMS data to identify beneficiaries in relatively poor health—those with projected spending at least twice as much as that for the average Medicare beneficiary. Contracts with odds ratios over 1.25 were designated as having health-biased disenrollment and contracts with odds ratios of 1.25 or less were considered to be without health-biased disenrollment.

Survey response rates varied by contract, and beneficiaries were able to select more than one reason for disenrolling from their contract. Reasons are composites of individual questions created by CMS. We analyzed those responses that CMS determined were reliable.

CMS Does Not Identify Health-biased Disenrollment as Part of Its Routine Oversight of MA Contracts

CMS does not identify patterns of disenrollment by beneficiary health status in its routine oversight of MA contracts. Account managers in the 10 regional offices are the CMS officials responsible for overseeing these contracts. To do so, CMS officials told us they follow a standard performance monitoring protocol designed to determine whether the contracts adhere to all program requirements and need additional scrutiny. As part of their review, the account managers examine a variety of contract performance data, including MA Five-Star ratings, beneficiary complaint rates, and data on significant changes in drug coverage. Overall contract disenrollment rates are included in the MA Five-Star

Rating System provided to account managers to identify contracts that may need closer scrutiny. However, CMS officials told us these rates do not include information on beneficiary health status.³¹

In addition, CMS's account managers do not use the information CMS collects in the Disenrollment Reasons Survey in their oversight of MA contracts. The survey asks beneficiaries about the reasons they have disenrolled from their MA plan, and CMS officials told us that that CMS develops the survey reports and distributes them to MAOs annually to help them facilitate quality improvement efforts. The survey results are also made available to the public on CMS's Medicare Plan Finder website so that beneficiaries considering enrollment in an MA plan can learn why beneficiaries have chosen to leave a particular plan.

Given the data account managers use in their oversight of MA contracts, CMS is unlikely to consistently identify contracts with health-biased disenrollment as needing extra scrutiny. As part of its ongoing analysis of contract performance data, CMS identified 63 contracts as potentially requiring additional scrutiny in 2014. However, this list included only 9 of the 35 contracts we identified as having health-biased disenrollment. CMS classified 2 of the 9 contracts as potentially requiring what the agency describes as "intensive monitoring," which may include dedicated monthly meetings between the account managers and MAO representatives to discuss problem areas. CMS identified the other 7 contracts as requiring some additional monitoring, which may include at least one meeting between the account manager and MAO representatives.

CMS has available data that its account managers could use to monitor contract disenrollment rates by beneficiary health status. Disenrollment rates are one of the measures used in the MA Five-Star Rating System; we used CMS's beneficiary risk scores, which are based on demographic and diagnosis information, to identify beneficiaries in poor and better health; and the Disenrollment Reasons Survey provides information on why beneficiaries disenroll from their plans. As we have shown, contracts

³¹CMS officials told us that since disenrollment rates are only 1 of up to 45 quality and performance measures in the MA Five-Star Rating System, disenrollment alone would have a small effect on contracts' overall star rating. Furthermore, the officials explained, disenrollment rates have a limited effect on whether contracts are identified as warranting additional review, as a contract's star ratings are combined with the other performance indicators account managers use in their ongoing oversight.

with health-biased disenrollment had lower quality scores, and beneficiaries who disenrolled from these contracts more commonly cited problems with coverage of preferred doctors and hospitals as well as problems getting access to care as leading reasons for disenrolling. As a result, the survey data could be used in conjunction with the other available data to reveal unique information about contract performance that other data do not show.

By not analyzing disenrollment rates for signs of potential health-biased disenrollment, CMS account managers may fail to identify problems in MA contract performance. This poses a risk to beneficiaries, given that MA contracts are prohibited from limiting or conditioning their coverage or provision of benefits based on health status and must ensure adequate access to covered services for all beneficiaries. CMS's oversight is also inconsistent with federal internal control standards, which call for agencies to identify, analyze, and respond to risks.

Conclusions

CMS is responsible for ensuring that all MA contracts offer care that meets applicable standards, regardless of beneficiary health status. However, as part of its routine oversight, CMS does not examine disenrollment rates by health status. Our analysis identified 35 contracts in 2014 where MA beneficiaries in poor health were more likely to disenroll than those in better health. These contracts with health-biased disenrollment had quality scores that were consistently and substantially below the scores of contracts without health-biased disenrollment. In addition, survey data indicate that beneficiaries who left these contracts reported problems with coverage of preferred doctors and hospitals as well as problems getting access to care as leading reasons they chose to leave their contracts. This type of information on disenrollment and beneficiary health status is available to CMS; however, by not leveraging it as part of its routine oversight of MA contracts, CMS is missing an opportunity to better target its oversight activities toward MA contracts that may not be adequately meeting the health care needs of all beneficiaries, particularly those in poor health.

Recommendation

To strengthen CMS's oversight of MA contracts, the Administrator of CMS should review data on disenrollment by health status and the reasons beneficiaries disenroll as part of the agency's routine monitoring efforts.

Agency Comments

We provided a draft of this report to HHS for comment. In its written comments, which are reprinted in appendix II, HHS concurred with our recommendation. HHS noted that it currently uses disenrollment data in its review of MA plan quality and performance and will continue to consider ways of incorporating disenrollment data in its oversight. HHS also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the appropriate congressional committees and the Secretary of Health and Human Services. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report.



James Cosgrove
Director, Health Care

Appendix I: Selection of Contracts Included in Our Study

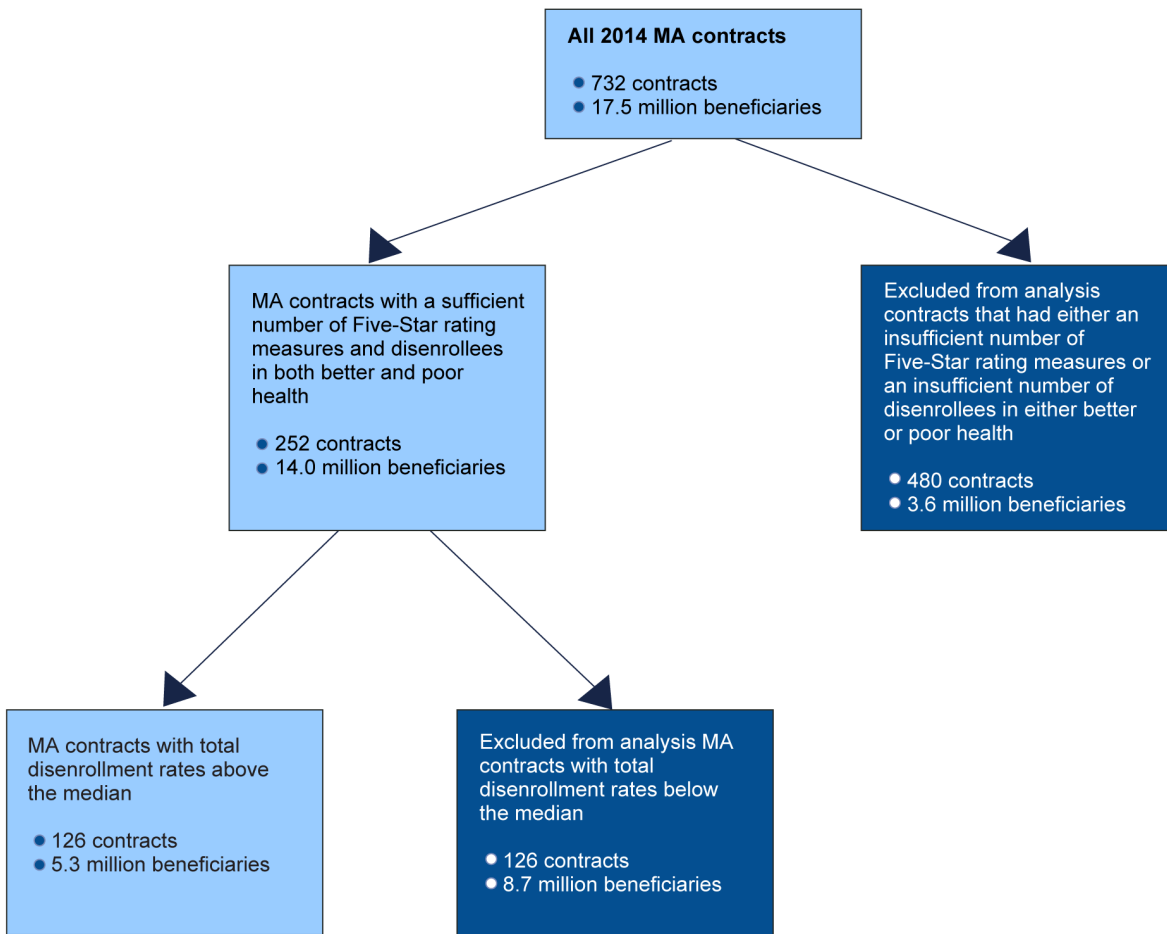
Using data from the Centers for Medicare & Medicaid Services (CMS), we examined enrollment and disenrollment in 2014—the most recent year of data available at the time of our analysis. Of the 732 Medicare Advantage (MA) contracts in 2014, we excluded 480 contracts, with 3.6 million beneficiaries, from our analysis. These were contracts with fewer than 100 beneficiaries in poor health who disenrolled from the contract in 2014, fewer than 100 beneficiaries in better health who disenrolled from the contract in 2014, and contracts for which CMS reported fewer than 50 percent of the individual measures in the 2016 MA Five-Star Rating System—which largely reflected performance in 2014.¹ These contracts were excluded because they did not have a sufficient number of Five-Star ratings, or had low contract enrollment. The remaining 252 contracts accounted for 79.7 percent of the 17.5 million beneficiaries enrolled in an MA contract in 2014.² We then ranked the 252 contracts in terms of their total disenrollment rate, identifying the 126 contracts with disenrollment rates higher than the median of 10.6 percent as having relatively high disenrollment.³ In our analysis we focused on these 126 contracts because they had relatively high disenrollment as contracts with below median disenrollment may not warrant the same level of oversight scrutiny as those with higher rates. (See fig. 4.)

¹We used CMS risk score data to identify beneficiaries in relatively poor health and those in relatively better health. Beneficiaries whose projected spending was at least twice as much as that for the average Medicare beneficiary were classified as being in poor health, while beneficiaries with projected spending less than that amount were considered to be in relatively better health.

²Beneficiaries may have been enrolled in more than one contract in 2014, and our 17.5 million beneficiary enrollment calculation accounts for the total number of contract enrollments. According to CMS, there were 15.9 million unique beneficiaries enrolled in 2014.

³Data on contract disenrollment rates account for beneficiaries who disenrolled to join traditional Medicare or a plan offered under a different contract; the rates do not include beneficiaries who enrolled in another plan offered under the same contract.

Figure 4: Selection Methodology for Medicare Advantage (MA) Contracts Included in Our Study



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-17-393

Appendix II: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

APR 12 2017

James C. Cosgrove
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. Cosgrove:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*MEDICARE ADVANTAGE: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight*" (GAO-17-393).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Barbara Pisaro Clark".

Barbara Pisaro Clark
Acting Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: "MEDICARE ADVANTAGE: CMS SHOULD USE DATA ON DISENROLLMENT AND BENEFICIARY HEALTH STATUS TO STRENGTHEN OVERSIGHT" (GAO-17-393)

The Department of Health & Human Services (HHS) appreciates the opportunity to review and comment on the Government Accountability Office's (GAO) draft report. HHS is committed to ensuring that Medicare Advantage organizations do not discriminate against beneficiaries due to health status.

In the Medicare Advantage (MA) program, HHS enters into contracts with Medicare Advantage Organizations (MAOs) to offer health insurance products to Medicare beneficiaries. MAOs must provide coverage for all traditional Medicare services; however, they are paid fixed monthly payments that are dependent upon the relative health status of the MAOs' beneficiaries. HHS conducts oversight of MA plans offered by MAOs to ensure that they comply with federal law regarding beneficiary protection, including anti-discrimination provisions.

As part of its review of an MAO's bid submission to Medicare, HHS evaluates each plan benefit package to ensure that it does not offer cost-sharing structures or plan benefits that encourage disenrollment, steer specific subsets of Medicare beneficiaries to particular MA plans, inhibit access to services, or include supplemental benefits that only appeal to healthier beneficiaries. HHS also analyzes data to ensure that all required benefits are covered, that cost sharing complies with Medicare restrictions on out-of-pocket costs, and that Medicare network adequacy requirements are met. Once an MAO's bid is approved, HHS continues to conduct oversight of the plan.

As required by the Balanced Budget Act of 1997 (PL 105-33), HHS measures and publicly reports the quality and performance of MAOs and Prescription Drug Plans (PDPs) on the Medicare Plan Finder tool on www.medicare.gov. This helps beneficiaries make informed choices by being able to consider a plan's quality, cost, and coverage, incentivizes quality improvement, allows for oversight and quality monitoring, and is used to determine Medicare Advantage (MA) Quality Bonus Payments. Further, the Act mandates that two years of disenrollment information be displayed.

The Medicare Advantage Star Ratings Program currently includes up to 44 unique quality and performance measures, of which 32 measures are for health plans and 15 for drug plans.¹ These measures are rolled up into the summary level measures, with different weights by type of measure. The MA Star Ratings include a measure (Members Choosing to Leave the Plan) that is calculated based on the disenrollment data. The voluntary disenrollment measure counts members who disenroll for a number of reasons, including voluntary disenrollment through the plan.

¹ The rating system has been available since 2007 for Part D and 2008 for Part C.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: "MEDICARE ADVANTAGE: CMS SHOULD USE DATA ON DISENROLLMENT AND BENEFICIARY HEALTH STATUS TO STRENGTHEN OVERSIGHT" (GAO-17-393)

HHS regularly conducts oversight through its HHS Account Managers and other mechanisms to ensure that MA plans are meeting all regulatory requirements, including ensuring MA enrollees are provided equal access to health care services regardless of health status.

GAO's recommendations and HHS' responses are below.

GAO Recommendation

To strengthen its oversight of MA contracts, HHS should examine data on disenrollment by health status and the reasons beneficiaries disenroll.

HHS Response

HHS concurs with GAO's recommendation. HHS currently uses disenrollment data in its review of quality and performance of MA plans through the MA Star Ratings. However, HHS will continue to consider ways to incorporate disenrollment data into its oversight of MA plans.

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

James Cosgrove, (202) 512-7114 or cosgrovej@gao.gov

Staff Acknowledgments

In addition to the contact named above, GAO staff who made key contributions to this report include Rosamond Katz (Assistant Director), Richard Lipinski (Assistant Director), Will Crafton (Analyst-in-Charge), and Betsy Conklin. Also contributing were Krister Friday and George Bogart.

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